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The art of medicine

Virtue in defect: the 9-year-old hero

The bravest person I know is a 9-year-old boy. I came to know him by chance and his story profoundly moved me. I will call him Cain, after the impulsive and hot-tempered son of Adam. The Cain I know is also impulsive. He suffered brain damage in utero due to prenatal alcohol exposure and was diagnosed with fetal alcohol spectrum disorder (FASD). His birth mother, who was herself in care as a child, had neither the education nor the resources to refrain from drinking during pregnancy. Cain was taken into care at birth; but it was too late.

Cain's condition causes emotional dysregulation, executive dysfunction, memory deficits, and social deficits. As a result, he has behavioural and emotional regulation problems, which have led to him being all but excluded from one school and requiring additional support in the school he now attends. What comes easily, indeed enjoyably, to most other children his age—playing sports, going to beavers, or having a sleepover—is a struggle for him. Cain can be incredibly challenging; even at the best of times he functions at a level far below his chronological age and is prone to outbursts typical of younger children.

On a good day, Cain can be loving and happy, if boisterous and loud (sensory processing problems). On a bad day, he might lash out, damage things, or run away. He is easily overwhelmed and can quickly feel cornered, going into “fight or flight” mode. On those days it is hard even for those closest to him to understand. His behaviour can be frightening and overwhelming.

Cain's neurodevelopmental disorder is invisible. He superficially appears ordinary, his disability masquerading as character flaws, leading people to judge him harshly as rude, loud, or selfish. Cain is observant and notices such judgements, and that things are going badly for him. He knows he cannot do many of the things his peers can: he cannot manage himself in social situations; he cannot take up a hobby; he needs to be constantly supported by an experienced adult. He can be a volcano, a hurricane. He is also a child.

Imagine the life of a child with such a disorder. Every day he gets told off dozens of times for behaviours he cannot control and often does not understand or remember. His flawed working memory causes confusion and apparent oppositional behaviour. What was I asked to do? Why am I holding scissors? He struggles to follow instructions because of memory and executive function deficits, and the ensuing difficulties at school, home, and in social contexts lead to isolation and an increasing sense of failure.

According to the Greek philosopher Aristotle, human flourishing requires cultivating our virtues, understood as excellences of character. Our goal is to achieve such flourishing. But what do we say about a child with FASD, who cannot excel or be virtuous through no fault of their own? How can we demand of such a child to overcome temptation, persevere at tasks, or show generosity, when prenatal alcohol exposure has damaged the parts of their brain responsible for impulse control, planning, and empathy?

Are such children doomed to failure, unable ever to flourish? This, I believe, is the ethical challenge disorders such as FASD present. A challenge that Aristotle did not, of course, address. In his *Nicomachean Ethics* Aristotle focuses on a narrow range of forms of life, all of which implicitly presuppose mentally and physically typical persons. Indeed, he discusses two kinds of reasons that lead people to act “incontinently” (fail to do what they ought to). One is brutishness; the other morbidity. Both are incompatible with the pursuit of virtue for Aristotle. Morbidity (sickness and disability) in particular is cited as an explanation for the inability to strive towards virtue.

I suggest that we should expand Aristotle’s account so as to affirm the possibility of flourishing against a background of limitation and impairment. That would enable cases like Cain’s to be properly enfolded into the range of visions of the good life. More broadly, I argue for the possibility of flourishing within the context of illness, even in situations where it seems impossible to the outsider.

First, let us consider whether a person deserves additional moral brownie points if in order to act virtuously they had to overcome a vice. Are they more virtuous than the person who is naturally kind, thoughtful, or friendly? Some philosophers insist that an element of hard work, devotion, and cultivation is needed for genuinely virtuous action. On their view, to be genuinely virtuous a person needs a reflective relationship with virtue, of a sort achieved through intellectual and practical struggle.

What about someone with neurological damage, such as a child with FASD? For Aristotle, the possibility of virtue is removed—or radically limited—in such instances. For a person with sufficiently severe neurological damage is simply unable to cultivate virtue, at least of the reflective sort that he most prizes. Aristotle considers physical injuries to fall under the same category: they prevent the disabled person from developing the sort of capacities needed to be fully virtuous. On his view, one cannot cultivate those excellences without the underpinning mental and physical capacities because one is unable to engage in the sorts of activities (civic engagement, philosophical reflection, and social agency) required for realisation of the distinctive ends of human life.

However, Aristotle's account is too restrictive. We need to start with a broader sense of human life than he had, and build diverse conceptions of virtue, relativised to the context of an individual life. Thus, the child with FASD may consistently fall short of the standard achieved by his peers. He will not be as patient, considerate, or cooperative as neurotypical children. But might his mode of flourishing be of a different kind altogether?

I suggest that there is virtue in ill and disabled people's lives and actions, but that this excellence remains invisible when measured against our usual standards. Reflect, for example, on the courage, fortitude, and optimism required from a child with FASD each morning as he gets ready for school. He knows the day will be an emotional and sensory roller-coaster ride. He knows that he will be treated in a patronising or impatient way and that he will be told off for things that are beyond his control.

And yet, he will courageously—possibly more courageously than we can imagine—get himself ready to the best of his ability and set out to live another day in his bewildering, overwhelming, and often frightening reality. What virtues are exemplified by the simple act of walking out the door with his schoolbag? These achievements are invisible to us, because they are seen as mundane. In fact, they are virtues that are not only more intense than those we are familiar with, but also belong to a different mode of excellence altogether: excellence stemming from defect.

A person's circumstances and their bodily and other capacities will affect two things. First, what counts as virtuous activity—for example, what counts as courage, tenacity, or discipline—for a particular person. These must be relativised. For some people, the threshold for virtue is lower, or altogether different. Second, what the relevant “table of virtues” is for a person is similarly variable. Maybe attentiveness and reflectiveness are not virtues for everyone, since, for some people, sensory and cognitive impairments preclude their developing those virtues.

This point applies more broadly. Think of children and adults with other disabilities. They, too, are called upon more frequently and more intensively than the healthy and able-bodied to display courage, patience, equanimity, and tenacity. It is crucial that we acknowledge their additional efforts as such, especially in the context of a health-care setting, where such recognition is further obstructed by time pressure, formalised interaction, and institutional structures.

When relating to their patients, health professionals should beware of having a restrictive conception of what the good life is or what constitutes flourishing. Our society and individuals within it, including health professionals, policy makers and social care professionals, make tacit assumptions about illness and disability that preclude some patients from participating in our shared vision of the good life. We need, as a society and as individuals caring for ill and disabled people, to be open to what individual people can achieve within their own life's context that can be disabling or difficult

in a variety of ways. I call on us to recognise that everyday coping by itself is an achievement when executed against a backdrop of deprivation, impairment, and suffering. For a patient with a respiratory disease whose lung function is impaired, a short walk to the shop returning with a pint of milk can signify a victory over her impairment. For the child with FASD, managing break time without a physical fight is a noteworthy success.

Aristotle advocated ethical investigation that starts with a systematic exploration of the natures, capacities, and dispositions of human beings as they are, and develops a conception of our virtues and the good life from that. Where Aristotle went wrong was in using only a very narrow diet of examples. It would not have occurred to him to look at the ill and so-called “defective” as anything other than deviations from the norm. But we can do better than that. By ‘doing better’ I mean fully realising the project that Aristotle initiated, broadening the forms of human life that are available for ethical reflection. It is an exercise of virtue in itself to gain insight into the plurality and complexity of life-contexts, and a clinical virtue that clinicians ought to cultivate.

Cain is a hero. Each day he wakes from a fitful sleep punctuated by nightmares. He cannot get ready for school without help or remember what day it is. He has limited ability to work with peers, sustain friendships, or understand the consequences of his actions. But as he grows older, he will increasingly need to make his way in the world: a vulnerable young person with both deficits and virtues that go largely unacknowledged. Let us recognise the possibility of flourishing, albeit flawed and partial, for him and others in similar situations. Recognising flourishing within the context of illness, disability, and impairment will move us from a deficit-centred to a possibility-based view of such conditions, and to increased pluralism in our view of the good life.

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Further reading

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